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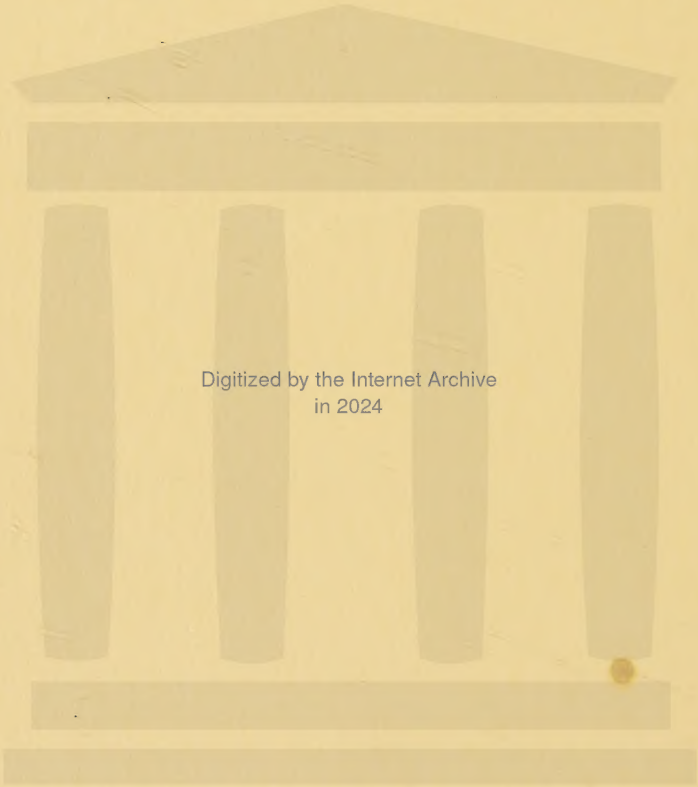

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delphia 25, Pennsylvania.

STATEMENT OF AIMS

BRING together descriptive accounts of pastoral work with individuals groups, in parish, hospital and prison, and to encourage parish clergy chaplains to share their understanding and methods.

DEMONSTRATE the use of concise note-taking in clarifying the pas- l process and in providing a factual basis for pastoral work.

CLARIFY; from specific pastoral situations, both the religious needs he parishioner and the principles of relating to other professions also cerned with a ministry to people; especially medicine, penology, social k, nursing and education.

USE the insights of other professions, not in imitation of these profes- ns, but as a means of further strengthening the clergyman's understand- of the needs and resources of his people and of his role and relationship hem.

THROW light on the elements of normal Christian living through ical accounts of the pastoral care of the adequate and wholesome person.

CONSIDER the principles and methods of Clinical Pastoral Training of theological student, the nature of the supervision involved, and its rela- n to other elements in the curriculum; recognizing the growing interest his educational approach in helping the student make real in under- nding and practice his work in the seminary.

SOME PRACTICAL PROBLEMS IN COUNSELING IN THE PARISH

CARROLL A. WISE

The author has recently been appointed Professor of Pastoral Psychology and Counseling at Garrett Biblical Institute in Evanston, Illinois, and for three years previously was minister of counseling at the Hennepin Avenue Methodist Church, Minneapolis, Minnesota.

The purpose of this article is to discuss several questions which are quently asked by ministers in regard to practical problems in parish nseling. The answers grow out of an extensive background of clinical ning and experience and out of three years of counseling in a large church. Throughout this time there have been many series of lectures ministers. The questions discussed here are among those frequently d in these sessions and in personal conferences.

A word about the parish background may be helpful. For the past e years the writer has been "the minister in charge of counseling" at Hennepin Avenue Methodist Church in Minneapolis. This title exsses a staff relationship which is rather unique among churches. Henne- Church has a head minister in the person of Dr. Richard C. Raines. there are no "assistants" or "associates." Each of the five ministers the staff is known as a minister. As such, each man is expected to do a le of the general work of the church. Some preaching, calling, weddings, ching and general administration falls to each. But each man also has ajor area of responsibility. In this instance the major responsibility n the field of counseling. Actually this involves about three-fourths of time.

One problem which ministers raise comes in two forms. "How do you up a pastoral counseling program?" "How do you get people to come you?" These questions have to do with how the pastor makes himself ilable to his people for counseling.

This problem has been answered in various ways. Some have felt t the best approach is to set up a "clinic" or a "center." At Hennepin took a quite different approach. We proceeded on the assumption that storal counseling should be developed on the basis of organic growth, t is, growth from within the activity itself because of its inherent potiality and value. It was felt that the people would sense whether the ivity was sound, and would indicate their feelings by their freedom to e it.

It has been said in some quarters that the members of a parish are uctant to talk with their minister about personal problems. Some ve implied that techniques must be developed to coax or cajole people o the minister's study. As a general rule this is not true, though it may ply in specific instances. Again it is a question of making the counselor ilable.

In clinical training and chaplaincy experience the clergyman learn what it means to make himself available to persons in need. Among othe things he discovers the danger of aggressive actions in relation to th emotional and spiritual needs of his people. He discovers that a relationshi of trust and confidence is necessary, that one goes no further than a give person is ready to have him go, that the sick person must want to be helpe that part of his task is to be there when a person feels a crisis with suff cient clarity and urgency to seek help. He does not push in where he i not wanted, but he is aggressive enough to show that he is interested Part of the technique of a hospital chaplain is to go through the wards a regular intervals, or to meet the patients in some other way, so that thos who have developed a readiness for help may say, "I want to talk wit you." All of these lessons from clinical experience are highly importan in the parish.

Before the pastor makes himself available the church must mak him available, even as the hospital makes the chaplain available. Her the relationship of the pastor or counselor to the institution in which h serves is of primary importance.

In making a pastor available for counseling at Hennepin, severa things were done. First, counseling was interpreted as a natural part o the church program. It was not new. It had been going on all through th years. It was being expanded now for two reasons. One, the demand fo counseling on the part of the people had grown to the point where the staf did not have time to handle it. Two, it had become evident that the prob lems presented were of such a nature that a pastor with special training i counseling was required to handle them. These two facts made the coun seling an integral part of the total program from the beginning. In th act of calling a man for this purpose the church was giving expressio to a need of which it had become conscious.

A second thing was done at Hennepin by way of making the pasto available. This was at the point of the more formal aspects of the program These formal aspects were kept highly informal. There was no strong pub licity. Several interpretative statements were made from the pulpit, an one in print. The regular staff relationship was emphasized—the counselo was a minister of the church with full access to and by every member o the parish that this involves. The people were told that they could call th counselor directly. No secretary was used for appointments. Thus stric privacy was maintained and the confidential nature of the work was mad evident. But above all, the people felt that his time was aivailable an that they should not feel guilty in asking for it. It was their right an privilege, not to be abused but to be used.

This point of having time available is important for the pastor wh runs a church single-handed. It would seem that the essence of the problen

n the pastor's attitude. It depends on what he feels is most important. e pastor who conducts a counseling interview with the feeling "lets get ver with so I can get to something more important," will find that his ple will not come to him. The pastor who can organize his time on the is of what he feels to be relative importance of counseling in relation ther activities, and who can conduct his counseling in a relaxed frame mind, will thus make himself available. And in accepting the attitude he pastor, the church will make him available. For the comfort of some tors, it should be said that even though time was made available at nepin for counseling, the pressure of other demands was always so at that the actual counseling would have been reduced to a very small n had it not been constantly protected. The problem of pressure is solved even with five ministers on the staff. In any situation it can be ed only by the attitude of the pastor and his ability to educate his rch to a recognition of the relative importance of counseling. This olves in part the skill of the minister in counseling in relation to his l in other aspects of the ministry. Even though the need be great, some nisters would do well to avoid an emphasis on counseling because their lls lie in other directions.

Within this general background the counselor, as a pastor, seeks to ke himself available. This is the second approach to the question, "How you get people to come to you?"

We have already spoken of some of the lessons which clinical train- teaches us at this point. A major issue lies in the way the minister ndles his relationship to his people.

A minister coming into any church finds some attitudes already crys- ized toward him. The people have had other ministers. They have l expectancies which have been fulfilled or frustrated. They have learned think of their minister in certain definite terms. The general relation- ps between pastor and people in itself creates various and diverse atti- es. Experiences with specific ministers have developed both positive l negative aspects of these attitudes. So the pastor must begin where people are, with the attitudes which they have toward him because the role which he occupies.

Beginning on this level of professional relationship the pastor who uld make himself available as a counselor must move toward a rela- nship on a more personal level. Some people, driven by the intensity of ir problem, or on the advice of others, will come easily to a minister om they do not know prsonally. This was demonstrated at Hennepin en after a month the counseling schedule was pretty well filled. How- r, the average person waits. He wants to get acquainted, to know pastor before he enters into a counseling relationship. He wants the tor to move from a purely professional relationship to a more personal, imate, friendly relationship. The pastor who can move this way with

his people will find his people quickly responding toward him in the sar way. The pastor who carries on his personal relationships behind a vene of professional manners and attitudes will hold people away from him

The regular program of any church offers an unusually good chann for developing the kind of relationship which makes the pastor availab to his people as a counselor, providing the pastor has it within his pe sonality to do so. Speaking, teaching, calling, various social contacts, cor mittee meetings and other activities are opportunities. It happens wheth the pastor is conscious of it or not. Said one man at Hennepin, "I watch you for several months befor I felt I knew you well enough to be able talk with you."

The pastor who is conducting worship and preaching every Sunda has an unusual opportunity to allow his people to come to know him. H attitudes in conducting worship, in praying, in preaching are quickly fe by the congregation. The people feel a freedom to come to him, or the feel a barrier. Many specific personal factors in the pastor and the peop alike control these reactions. But the pastor makes himself available as counselor as his people come to have a warm, affectionate attitude towar him. In other words, he becomes available as the people find a positiv answer to the question, "How far can I trust him with my problem?" Th is a personal question and it is answered only through personal relatio ships.

Another question is being asked today. "Is the pastor equipped b training?" People want to know if the pastor has something beyon good intentions, if he is capable of dealing with their situation. As or girl asked, "Are you really trained in counseling, or are you just anothe minister?" She had been to four ministers. They had given her advic which was logical enough, but really terrifying. They had told her t pack her bag and leave town. The guilt and anxiety which she fe about such a step was more than she could stand.

How should the minister let people know that he is equipped b training. Certainly not as one minister, who had no clinical training di by advertising himself as a "psychiatric counselor." And not by advertisin his training, even if he had good training. There is an impression c quackery in such procedures that raises doubts in many minds.

This writer came to Hennepin with fourteen years of mental hospita training and experience behind him. That was all soft-pedalled. Ou belief was that such knowledge would not be understood and that it woul threaten people. As the church has come to know the counselor bette the knowledge has seeped out, and it has been accepted because the cou selor first was accepted.

Being equipped by training has an implication in the mind of th average parishioner that goes beyond formal courses. The people war

urance, not only that the minister knows the field, but also that he ws how to use what he knows. They have met and heard about too ny book-trained counselors. They also are very easily threatened by nt the minister knows about them and how he uses what he knows. y want him to be competent, but not to know more about them than y are ready to reveal. They want him to be trained, but feel insecure en training is over-emphasized. When the question of calling a coun- ng minister was being discussed in the Official Board of the church one n said, "I am not sure I want such a man here. I am afraid he will choanalyze me." The feeling behind that statement is the fear that a wledge of psychology will give a person the power to see more deeply o othr minds than is desirable, and that he may use his knowledge ersely.

Quiet reassurance is the best promotion. The average person still much faith in "common sense," and will accept a minister as competent hey feel he combines his specialized knowledge with common sense. ading technical knowledge, using psychological vocabulary, using il- rations from counseling in sermons or speeches in ways that reveal fidences or imply unacceptable interpretations,—such procedures are eats. Tempering knowledge with understanding, meeting the people on ir own level, allowing them to set their own pace, dealing with the ds of which they are aware, being humble before the forces that make life or death, being human rather than 'professional,'—these and simi- attitudes give people the feeling that at least the counselor will not his training against them.

The results at Hennepin amply justify the principles which have been lined here. The attitude of the church as a whole is one of acceptance. unseling is being seen as a necessary balance to the group procedures the church, to preaching, worship, religious education. The discovery been made that group procedures go only so far in the solution of otional difficulties. Beyond that point individual attention is required.

The other result has been the heavy and constantly increasing demand. the end of the first year, the demand was so heavy that counseling had be restricted to members of the church. In turning others away, an empt was always made to refer them elsewhere, but here the commu- y resources were utterly inadequate. From among our own members the nand at times has been heavier than could be adequately handled. It often not good to keep people waiting two or three weeks for an ap- ntmnt, but that has been necessary.

In conclusion, clinical training which brings the pastor into a first- id relationship with people who are suffering, and which does this ler competent guidance, is our best approach in training ministers to ke themselves available to their people. As the pastor makes himself ilable the people will rspond.

MINISTERING TO THE SICK

ROLLIN J. FAIRBANKS

The author is Executive Director of the Institute of Pastoral Care, Lecturer in Pastoral Theology at Harvard, and Assistant Professor of Practical Theology and William Lawrence Director of Field Work, Episcopal Theological Seminary, Cambridge, Massachusetts.
This paper was presented originally as one of the Starr lectures before the alumni of Trinity College, Toronto, September, 1947.

Ministering to the sick is not primarily a healing ministry. This ma sound somewhat callous but it constitutes a basic premise if we are to ex amine thoroughly our ministry to the sick.

We have heard a great deal about religion and health. Illustrations o faith healing and miraculous cures brought about by religion are alway newsworthy. The writer himself functions much of the time within th walls of a great medical (and hence healing) center. Our clinical trainin of theological students and parish clergy is conducted with the assistanc of faculties of medical schools. Ministers and physicians should know eac other better and should cooperate more effectively.

Religion and physical health, however, do not necessarily go together Some of the healthiest people physically are not particularly religious Likewise some of the most devout and consecrated souls I have known ar burdened with ill health. Furthermore, to emphasize the *therapeutic* rol of religion is likely to lead us into Christian Science and eventually to th back waters of agnosticism which first plagued the Church in the secon century. Religion would become the handmaiden of health and the medica sciences. Christ did not die that we might have health and have it mor abundantly. Furthermore health is a transient, temporal thing and surel God as revealed to us through Jesus Christ is as interested in our eterna destiny as with our physical well being.

This was illustrated in a simple, homely fashion by a somewhat un lettered sixty-nine year old widow who was hospitalized with a fractured hip. As soon as I had introduced myself she said, "Chaplain, I don't wan you to pray fer my leg. The doctors are takin' care of that—and doin' a good job, I guess. I'd like fer you to pray fer that part of me they can't d nothin' about. I've been doin' a lot of thinkin' lately . . ."

Our primary goal as Christian clergymen is to strive for the building of the Kingdom of God. This means leading people to a closer alliance wit God and the salvation of individual souls. Granting man's natural aliena tion from his Creator (without going into the matter of original or uni versal sin), our ministry, therefore, becomes one of reconciliation—recon ciling man to himself, to his neighbor, and to his heavenly Father.

Once this primary objective is understood and accepted in ministering to individuals, then we can with greater freedom examine *secondary* bene

which may result from such a ministry, as well as the specific problems which we may be privileged to assist.

Religion can and does help the sick person progress toward health. ministry can and sometimes does seem to release or precipitate the *medicatrix dei* (as Dr. Richard Cabot has called it[1]) or the healing power God, which in some way serves to bring about healing and even eventual e. This happens infrequently but undeniably.

There are other times, however, when religion does *not* affect the gress of disease but instead enables the sick person to adjust to his ess and possibly prepare for his death—if the illness is of a terminal ure.

cial Problems

Before considering specific acts, techniques, or ministrations which a tor can do for a sick person, let us examine the multiplicity of situaıs one may encounter in ministering to the sick.

First we have those who are physically ill. This does not rule out cer- ı emotional factors but at least the primary problem is physical in na- e such as a fractured hip, a cerebral hemorrhage, or ruptured appendix. e cause of the illness may be an infection or a germ, or it may be some ury or trauma. The circumstances leading up to the sickness may (or y not) have some bearing upon the sick person's sense of responsibility his plight. Such things as drunken driving, sexual promiscuity, and empted suicide have moral implications.

The illness may be "chronic" (i.e. long-term) in character, such as erculosis, arthritis, certain neurological and circulatory diseases. On other hand it may instead be "acute" or of short duration.

There is the ill person whose condition is admittedly critical. If he nospitalized, his name will in all probability be placed on the "danger ." If he is at home the physician's call may be more frequent and the vices of a nurse may be required.

There is also the convalescent who is merely waiting for time and ure to restore his health. He feels more like reading, more desirous of iting, and oftn less aware of the need of the resources of religion.

What about the mentally ill, the psychiatric patients, about whom we ve heard so much in recent years? Again we encounter a variety of sitions. There are those individuals suffering from "mild disorders" ich are usually classified as neuroses. There are many more who are

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R. C. Cabot and R. L. Dicks, *The Art of Ministering to the Sick*, New York, Macmillan, 1936.

victims of "severe disorders" whics are classified as psychoses. This grou is generally less accessible, pastorally speaking, because of their eclusiv ness, bizarre concepts of what constitutes reality, their delusions of persec tion, and their frequent hyper-activity or manic behavior.

There is also a third group composed of border-line situations: th always baffling alcoholic, the truly tragic feeble-minded, the amoral psych pathic personality, perhaps an occasional epileptic who really belongs i another category. These, too, are children of God desiring, needing, an sometimes responding to the ministries of the Christian Church.

Often the individual's family is in equal need of help. This is partic larly true of those burdened with the problem of mental illness. Questio of hospitalization, shock treatments, lobotomies and other drastic or rad cal treatment must be borne by the relatives. The parish minister can b extremely helpful at such a time, particularly if he is reasonably familia with the proposed treatment and can control a natural desire on his pa to decide matters *for* the family.

There are other interesting variations—at times they may constitut obstacles—which one may meet when endeavoring to minister to the sic For instance, occasionally, we are asked to call on strangers, people who we have never seen nor heard of before, and thus we cannot rely on earlie relationships to guarantee rapport. Even if the patient *is* a parishioner o ours, his illness may reveal a different self or personality than we hav known before. Sickness is a time when the facades of everyday life ar down.

Resistance is another problem. It may be from the patient himsel his family, the hospital administration, nurses and physicians. It is common although unwritten policy of hospitals to shield their patient (especially those having private care) from the clergy.

The ward routine itself is filled with little incidents which often inter rupt or delay our pastoral care. The taking of temperatures, distributin mail, re-filling of water pitchers, uncompleted baths, taking our patient t the X-ray service, the brain-wave laboratory, or some other mysteriou department—all these and many more can happen during one pastora call! They need not always interfere, however, if we simply anticipat them and arrange with the nurse and ward clerk to cooperate in securin a brief period of privacy.

Often relatives or other patients compete for our attention, time, an service. The so-called "open" wards provide only the minimum of pri vacy. The curtains may be drawn about the bed but often they only serv to attract attention. When hearing confessions and administering Hol Communion drawn curtains are admittedly desirable. Prayers—with prac tice—can readily be offered at the bedside without any "screening."

Sometimes it is more difficult to secure privacy in the home than in hospital. Relatives often crowd into the sick-room during a pastoral and it requires a certain amount of tact to re-arrange the situation hout making the patient feel apprehensive and the relatives feel that y are being dismissed.

Occasionally we encounter a deaf patient. Should we attempt to con-se in a loud voice? Or should we write notes? A glance at the bedside id may reveal whether writing materials have been in use. It will be est, perhaps, to consult the nurse as to the best means of communica-. Prayer that is too audible may disturb other patients as well as cre-self-consciousness for the minister. Silent prayer is preferable but we uld indicate when the prayers are completed, otherwise a devout soul continue to keep her eyes closed and hands clasped for the rest of the ! I usually take the patient's hand or place mine on his arm and indi-the end of our devotions by releasing the grasp or pressure.

An oxygen tent or mask may present another barrier. If we believe astorally desirable to dispense with such temporarily, we should con-with the nurse first. Ordinarily silent prayer plus some physical con-such as taking the patien't hand is the best procedure.

derstanding the Patient

What about the experience of illness itself? How does it affect the ividual? It is always dangerous to rely on generalizations, never-the-certain reactions—particularly on the emotional level—are more often sent than not.

The needs of a pre-operative patient, for instance, will differ some-at from those of an individual who is post-operative. The former's ieties are likely to deal with more unknown and unpredictable situa-is, while the post-operative patient's anxieties more often concern esnt discomfort or recently unpleasant incidents.

Illness usually renders one more sensitive, thus we should seek to id clumsiness, excessive humor, long calls and, in general, strive for re pastoral finesse. Illness also is a frustrating experience, and frustra-makes for hostility. Hostility, in turn—to continue our little formula—ally finds expression through aggression. The result of all this is that netimes a sick person may manifest irrational resistance to pastoral e or he may indulge in unreasonable fault-finding. The "burr under saddle" is often the frustration of illness.

Illness (particularly if it involves hospitalization) is accompanied by usual and sometimes strange experiences such as simply having one's als in bed, using a bedpan or urinal, enduring enemas, wearing an ex-dingly abbreviated "night shirt," being given a bed bath by a young man, and many other "indignities" too numerous to mention.

This sense of strangeness makes for loneliness. Visiting hours ar brief. In the hospital one is among strangers; there is little or no pr vacy. There is a certain loss of identity. Every large institution (the churc as well as the hospital) is handicapped by an impersonal view of its mem bers. The patient, John Jones, for instance, too often becomes "the diabeti in Room 314." Mary Smith, for the time being, is no longer the mothe of three attractive children and the widow of one of the nation's grea heroes, but merely "a difficult ulcerative colitis case on Ward 7."

Loneliness sometimes leads into anxiety. Sick people are anxious abou many things besides their recovery. They may be concerned about finances employment, their families, etc. Their anxiety, in turn, may even develo into disturbing fears. Often these are vague (and hence more upsetting than they are specific (and hence more readily dealt with).

Humiliation is another very real emotional factor. Most adults do no enjoy being completely dependent on others, particularly for intimate serv ices. One's self respect or sense of modesty isn't shed as readily as hi clothes. The hospital personnel fail or refuse to acknowledge this, largel because they are victims themselves of what Dr. Cabot has discerningl described as the "illusion of routine."

Needs of the Patient

In the case of critical illness there are certain basic needs which w have been able to observe. First, there is the need to face one fear's, th imminent threats which hang over one's had. This confronting of real o imaginary danger, however, can rarely be done alone.

A second need is for additional strength. God may not "Give us an burden too great for us to bear," but this is difficult to remember or accep when one is struggling. By "additional strength" I do not mean physica stamina but rather something akin to morale, the ability to grit one' teeth a little harder, to "hang on," to "sweat it out."

The third need is for some some of religious affirmation or re-affirma tion. This is extremey difficult if the sick person has no real religiou foundation upon which to build. Never-the-less, as Cabot and Dicks hav pointed out, every one has a "growing edge" spiritually as well as otherwise It is the pastor's task, or rather opportunity, to discover that "growing edge" and build there.

For those who definitely already have a religious life, there is still th need for a strengthened faith. A wise sailor never relies on his usua mooring in time of a storm, but puts out other anchors. As one old mar put it, "Not that I don't believe in the Lord, Reverend, but I always like to talk to somebody else who believes in Him, too!"

The situation is somewhat different for those suffering from chronic or ng term" illness. First of all, they desire a genuine understanding of ir plight, and not merely superficial reassurance such as "I know *just* at you're going through" or "I understand *just* how you feel." If the gyman truly *does* understand, then it isn't necessary that he tell the ient, for the latter will readily sense that understanding. The word mpassion" comes from *patior* meaning "to suffer" or "feel and the fix *com* means "with." To suffer or feel *with,* to have a truly empathic tionship should be our pastoral goal.

Another need of the chronic sufferer is some sort of an adjustment to cceptance of the burden of the Illness. A third need is to discover op- tunities *within* one's limitations. Instead of concentrating on what the ess has denied the individual, he needs to recognize what privileges w though they may be) remain despite his sickness.

Still another need is simply some hope. Even though one's better judg- it, or one's reason tends to eliminate any optimism, man by nature t really a "quitter" and it is always healthy and desirable that he nurse g a little ray of hope.

The chronically ill person also needs companionship. Sickness tends solate and a long period of illness reduces to a minimum one's oppor- ity to inter-act with others. The presence of God at such a time can ome very real but it is not a substitute for human fellowship, and vice sa.

Finally, it is helpful for the chronically ill person to be assured that a tain amount of bitterness and frustration are to be expected and that re will be periods of "rough going." If these are anticipated, they are upsetting if and when they do descend upon the patient.

ological Questions

Theology in the class rooms must of necessity be theoretical. The ap- ach is rational, and the assumption is that the student is endowed with icient reason to assimilate such wisdom. The incentive is primarily one intellectual curiosity.

As we seek to develop our devotional lives, however, we become con- us of the fact that the God to whom we pray must be more than a losophical concept. We may know the ontological, the teleological, the mological, the other logical (and sometimes illogical!) theories of God, prayer calls for *life,* some form of *anima* or spirit.

This is even more true when one is ill, for then suffering, for instance, omes a *feeling* and not just a philosophical problem which arises pri- rily when one accepts the hypothesis of a God. Likewise, sin is not just

a concept but a gnawing sensation deep within one's soul—a very rea discomfort or torment which cannot be argued away or eliminated merel by labelling it a neurotic manifestation. (Incidentally, neurotic behavio still has ethical significance for society.)

So it is that we find within the sick room very real and sometime challenging theological implications. The nature and the reality of God for instance, is tested and measured in terms of this child's sarcoma of th scalp, a disfiguring cancer that may conceivably warp the little girl's fu ture life, if its malignancy permits her to grow into womanhood.

What about eternal life? Our class-room definitions seem out of plac in the sick-room. How unreal and hollow our reassurances sound! Can w meet the questioning eyes of the patient? Or must we stare at the floor—o out the window? Or do we frankly hurry off, a little annoyed that we wer made uncomfortable?

"What if I die? Do I go any place Will I meet anyone? Will I suffe more?" These questions do not call for sermons, lectures, arguments; the plead for understanding, compassion, pastoral affection.

"Why has this happened to *me?*" Why has it happened is an academi question until it suddenly happens to me. Then it becomes a *personal* ques tion of the first magnitude. The rational explanations of the problem o suffering almost sound inhuman, now that the problem concerns one's sel

Our awareness of sin returns frequently with illness. We may no like the word but that doesn't remove a growing awareness that evil o wickedness is both real and contrary to God's will. With such an awarenes comes a desire to know or experience divine forgiveness, intangible thoug it often may be. Many a patient desires to "set things straight" or "balanc the books."

Then, too, there is prayer. "Every day in every way I'm getting bette and better." Couéism- Auto-suggestion. Self-help. What about it? Tha man in the bed at the end of the ward—everyone knows he will never liv to go home. Yet, he puts his shawl about his shoulders, his cap on hi head, and enters upon his devotions, completely obvious of his surround ings. This woman who has three small children at home. She will neve walk again. How can one hope to raise a family with such a handicap She takes her beads in her hands, and the expression on her face tell us that she has something more precious than useful legs, something whic she can pass on to her growing children. In the sick-room our theorie about prayer are tested, just as are our other religious beliefs. Only con victions, however, can hope to survive.

How can we as Christian clergymen help all these people? How can w best serve as channels of God's grace to those struggling against the odd such as have been described?

Once in the sick-room, what *can* we do? All skills, techniques, pastoral hods will of themselves be of little value unless used to the glory of God. the other hand, *with* God's blessing they can enable us to bring the re- rces of the Christian faith to the assistance of individuals in need.

The first step is to establish a desirable pastoral relationship. This is ained by avoiding lengthy introductions, by listening, by restricting in- uptions to a minimum, always concentrating on the patient (even when ers seek to enter the conversation), withholding judgment, seeing the ld as the sick person views it.

We should avoid such stereotyped questions as "How are you feeling ay?" Likewise we need to guard against premature comments such as ou're looking much fetter today." Instead, we can open the conversa- n with a relatively "neutral" question such as "How is it going?"—and n watch for the response since it will indicate fairly accurately just at the patient's "emotional temperature" is at the moment.

This enables us to know, so-to-speak, just "where the patient is" and s begin our ministry on a realistic level. One is less likely to indulge in e, premature reassurance if he has first determined how the patient is ling.

The next step is to make some sort of a spiritual diagnosis. As a pro- sion we clergy are inclined to treat first and diagnose later. Too often offer prayer, for instance, before we have learned the specific needs of sick person. Some kind of an appraisal, therefore, is in order. Hiltner, his book *Religion and Health*[2], suggests three steps in making such a gnosis: (1) What are the personality resources? (2) What are the ational or social resources? (3) What are the spiritual resources? er studying the individual and his needs from these three angles, the ults are assembled into a "spiritual diagnosis" which should, in turn, icate the appropriate pastoral therapy.

There are several specific methods or ministrations available, some of ich are more familiar than others. There are those which might be de- ibed as sacramental in nature, although *all* pastoral care is but a mani- tation of the presence of an inner spirit. These "sacramental" ministra- ns, while not intended primarily for the sick, do offer us channels for a pful ministry.

There is first of all Holy Baptism which in recent years has been ticularly eclipsed by the strong emphasis upon Holy Communion. We d to think of this sacrament largely in terms of infants, with the result

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Seward Hiltner, *Health and Religion*, New York, Macmillan, 1943.

that we rarely think of it as a ministry to adults. The fact remains, how ever, that it is a *basic* ministry for those who wish to enter into the Chris tian fellowship for the first time.

"Illness makes you think," one man said, "and about things that ordi narily wouldn't cross your mind." He went on to ascribe how illness as a child had caused postponement of his baptism and self-consciousness dur ing adolescence did the same thing. Then he drifted away from the Churc until his marriage. His pastor had always assumed that he had been bap tized but never could understand why he avoided or postponed being con firmed.

"I never could talk comfortably with that minister," the man said, "s I just let sleeping dogs lie. Now, I don't feel quite right about it. I've trie to follow the Christian way but I've never done anything formal about it Do you ever baptize people like me"

Confirmation (or its equivalent) is a second ministry and one in whic we can participate. I have only presented two sick persons for confirmatio but for one of them it was part of a total ministry to her in her illness. Sh had begun receiving instructions on several occasions only to have it in terrupted by a recurring illness.

One day she remarked that she was no longer able to complete anythin nor to feel a part of anything because of her invalidism. When I suggeste that she be confirmed, her face brightened and she asked, "Could tha really be done?" Needless to say, few services have been more impressive

I have even known Holy Matrimony to contribute undeniably to one' medical progress! An elderly couple had been divorced fifteen years pre viously. After a five-year period of separation, they had renewed livin together but without the formality of re-marriage. Their two grow children, however, did not know of this omission and had instead assume that their parents were again legally wed.

The wife was now seriously ill with a congestive failure, her nam had been placed on the danger list, and she was not expected to live. Both she and her husband feared that their legal carelessness would be disclose if anything happened to her, and she was well aware of the seriousness o her condition. Being canonically unable to perform the ceremony myself, arranged for a fellow clergyman to officiate and served as one of the tw witnesses.

It was a pathetic service. The groom preceded us into the room t remove the original wedding ring which the patient wore, so that he coul once again place it on her finger! The oxygen tent was temporarily re moved from the patient and the ceremony performed with all due solemnity

The change in the patient's condition during the next twenty-fou

irs was so remarkable that her name was removed from the danger list, l two weeks later she was discharged from the hospital. A social worker ied on her about a month after that and found the "bride" busily getting als for the "groom."

Many of us are familiar with the profound and sacred significance of ly Communion. We must guard zealously against its becoming the ivalent of the Roman rite of Extreme Uunction. Certainly the dying uld never be denied Holy Communion, but neither should we wait until arishioner is dying before we suggest it!

Because a sick person usually has a shortened span of attention, it is ierally unwise to have a complete Communion service or celebration at bedside. Also, it is unwise for us or any one else present to kneel ing any part of the Communion service. It is possible to stand reverly,, as did the early Christians. To kneel beside a hospital bed is to disear completely. It is both startling and somewhat disconcerting for the ient.

The value of Holy Communion to the sick depends greatly upon the c person's pre-hospital associations with the sacrament. The frequency h which one should receive this sacrament will depend again largely on one's pre-hospital habits. Once the service is over, the clergyman uld leave the room even if only to return a few minutes later. It is inusable, irreverent and poor pastoral care to proceed directly from a mmunion service into a social visit.

Most hospitals will no longer permit the use of lighted candles. The iger of fire is too frightening to justify any protest from us. A small ss is frequently desirable as a focal point. A printed order of the rtened service with the responses underlined in red is of great assiste to the sick person and for any others who may be participating.

I have never used Unction nor has it been requested. Unless the sick son is thoroughly oriented as to its therapeutic function, its use will y lead to misinterpretation and a tendency to expect magical results. ese remarks in no way invalidate the use of this ministry. They serve tead as a warning lest our pastoral enthusiasm lead us to use an ancient d sacred ministry unwisely.

Neither have I ever used the apostolic healing ministry known as "the ing on of hands." A colleague of mine once did so in desperation in an ort to exorcize a young man in an hysterical condition which, incidenly, appeared later to be a homosexual panic. The clergyman ordered the ung man to kneel; he placed his hands firmly on the young man's head d prayed that God might relieve him of his burden. The upset fellow s visibly quieted by this rite.

The sacrament of Penance and the use of Confession are some time used by Anglo-Catholics, a group within the Episcopal Church. As voluntary devotional act in which the focus is on one's alienation fro God rather than simply an inventory of behavior, Confession is unques tionably of tremendous pastoral value. Again, however, it presupposes a orientation in Catholic practices which does not always exist. It "straight ens out past accounts," but because it deals primarily with behaviour an hence *symptoms*, it is not a substitute for exploratory pastoral interview which seek to get at *causes*. Confession without penance is a hollow prac tice that is likely to encourage exhibitionism or narcissism.

Let us now turn to some of the "non-sacramental" methods. The mos important of these is prayer which, in the presence of the sick person, shoul always be of a corporate nature. Intercessions can be offered at our altar or our *own* bedsides. When we are with the sick, let us pray *with* them an not "for" or "over" them.

We should avoid offering prayer before we know what to pray for Ordinarily I use several short prayers. The focus usually begins with th individual but moves on to others. For instance, I might begin with th prayer for "Quiet Confidence" (from the Book of Common Prayer), the the Lord's Prayer (in unison), followed by a prayer for "Those We Love" and close with a familiar benediction. In other words I start with the sic person but before I am finished our attention has moved on to others.

The use of Scripture can be a rewarding ministry *if* the patient is at all acquainted with the Bible and its Elisabethan style[3]. The selections should be brief, make sense, be read well, and preferably be familiar. It has been my experience that more sick persons prefer to have Scriptur read *to* them, than to read it themselves.

The use of religious literature has its place in the total ministry to the sick. Ordinarily only convalescent patients have the strength and, more important yet, the span of attention necessary for much serious reading Most devotional literature for those experiencing illness is sadly unrealistic and unattractively pious.. Here is an area in which more needs to be done better material prepared. One of the most realistic booklets I know was prepared by two Unitarian clergymen who sought through a little manual[4] to minister to the sick on their *own* level, not on the level where we clergy think they *should* be.

Reassurance, of course, is what is most expected of us. It is a form of supportive pastoral therapy. Its value varies in direct proportion to its sincerity and realism. Too often our reassurance is wishful thinking and

[3] Modern versions are better known to the clergy than to the laity.

[4] *The Lord is Our Strength*, pub. by The Order of The Devoted Life, 425 Congress St., Portland, Me.

s about as long as flowers from the altar. Frequently it is like "pouring on troubled waters" without discovering what the trouble is. Some times s as much a "pep talk" to ourselves as it is to those to whom we minister.

Strangely enough the mere act of calling on a person is a real min- y in itself. It serves to remind him that he is not forgotten, that he has ery real identity, that *we* care, *others* (i.e., the parish) care, and that *l* cares.

Maintaining moral neutrality or moral resiliency is also extremely im- tant, particularly if we hope to build strong rapport. The sick person usually in no mood to be censored; he has enough troubles as it is. He ds a spiritual advisor who cares most about *him* rather than what has done.

Still another "non-sacramental" ministry is that of quietness. It is to be confused with silence which is coercive and often irritating. ietness on the other hand, has a relaxed quality and is soothing. It iates a confidence that is contagious. In some ways it is a manifes- ion of *pax dei* or the peace of God "which passeth all understanding." ietness is reassuring and supportive and particularly useful with the very x patient.

We have not yet considered what is probably the most important nistry for the sick. While we have long been aware of its function and fulness, we are particularly indebted to Russell Dicks for "pointing it " "rediscovering" it, so-to-speak, and giving it once again its rightful ce, in our pastoral ministry. I am referring to the simple ministry of ening.

To listen can merely be a mechanical process or it can be a pastoral ocess in which the clergyman's genuine concern for the individual is nifested in a very real although intangible way. It is more than merely ng non-directive. Paul Johnson has wisely called it "responsive lis- ing."[5]

There are times when the pastor will deliberately postpone attempting guide the interview because tension is great and the abreaction or dis- arge of feeling constitutes a necessary catharsis. There will be other nes when it is definitely advisable to guide the discussion along certain es. At all times, however, such listening is an active, attentive, compas- nate process that enables the sick person to realize emotionally as well intellectually the pastor's genuine understanding and desire to help.

Ministering to the sick is part of our total ministry and offers excellent portunities for sharing the resources of our Christian faith. It also is a

[5] P. E. Johnson, "Clinical Psychology for the Pastor," *Journal of Clinical Training*, Vol. 1 (1945), 264-265.

discouraging ministry at times. Sick people want health, not religion—unless they think that religion can restore their health. Most hospital patients are more interested in going home than in being comforted. They want miracles, not prayers *for* miracles. They prefer the physician to the pastor.

Continually ministering to the sick is an extremely debilitating experience, spiritually and otherwise. We can readily become concerned and preoccupied with our own physical health. It is important that we re-charge our "spiritual batteries" from time to time. On the other hand, we frequently come across people to whom we can give little but from whom we receive much. Such individuals can teach us a great deal about the resources of the Christian faith. Perhaps this is God's way of tempering ordination with humility.

To summarize the foregoing presentation we might list the following conclusions:

1. Religion is not primarily concerned with physical health but can and does contribute to (a) recovery, (b) adjustment, and (c) preparation for death.
2. A routine ministry is impossible because of the multiplicity of situations which may be encountered.
3. Obstacles of hospital routine and treatment can be avoided or overcome by non-aggressive relationships with hospital personnel.
4. The needs of the sick are definitely related to the intensity, duration, and prognosis of their illnesses.
5. Illness often precipitates basic theological questions such as the nature and reality of God, eternal life, suffering, sin, divine forgiveness, and prayer.
6. Establishing a desirable pastoral relationship and making a spiritual diagnosis are primary steps in ministering to the sick.
7. "Sacramental" ministrations for the sick include baptism, confirmation, matrimony, communion, unction, "laying on of hands," confession, and penance.
8. "Non-sacramental" ministrations for the sick include prayer, use of scripture, reassurance, calling, moral neutrality or resiliency, quietness, and listening.
9. Ministering to the sick is often a debilitating experience and requires, therefore, that the clergyman's religious resources be frequently renewed and strengthened. On the other hand, it can also be a very enriching experience.

E SERVICE OF WORSHIP IN A MENTAL HOSPITAL: ITS THERAPEUTIC SIGNIFICANCE

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The occasion of this paper is a proposed revision of the hymnal[1] use in hospitals which the writer first compiled twenty-four years ago. ıas seemed worth while to formulate and re-examine the principles upon ich that volume was constructed, and to consider changes which now m desirable in the light of our accumulated experience in the ministry he mentally ill.

The assumption which underlies the compilation of such a hymnal is t the service of worship, which has been distinctive of the Hebrew-istian religion, is the outstanding exemplification of the group therapy which we hear so much today and that its employment in a mental hos-ıl calls for certain adaptations, if its potential effectiveness is to be lized.

The therapeutic significance of the service of worship can best be lerstood in the light of George H. Mead's theory that the personality the internalization within the individual of the group organization means of language.[2] It is, he holds, dependent upon the common re-nse to symbols which arouse in us the same response as they do in others. e personality is thus a set of social responses which have become organ-l and habitualized. According to this view the social response which is basis of the personality is not just to others in general but to those love and admire and whose authority we accept, those who for the re-ous man are associated with his idea of God.

Now any crowd is likely to evoke an emotional response in so far as s thinking and feeling together with reference to some common idea. he feeling is at all strong, the previous organization, which is depend-upon verbal symbols, is likely to be swept away. The response to the or-nized best may thus give way before the response to the present living ss. The mob is thus likely to do what the individuals who compose it uld not do in their sober moments. The mere mass of a crowd may thus ry it with a certain authority and the sense of identification with a wd—as felt at a football game or called forth by the sight of the nation's med forces on parade—is likely to carry with it a sense of exhilaration.

Hymns of Hope and Courage, New York, Harper's, 1937.

Mead, George H., *Mind, Self, and Society*, Chicago, University of Chicago Press, 1936.

In the case of a religious assemblage attention is consciously focused upon what is conceived to be supreme in the hierarchy of loyalties. The Christian Church thus represents to the believer the fellowship of the best and its meetings are designed to keep alive the loyalty to each other and the common loyalty to the God whom the worshipers regard as the source of their life, the controller of their destiny and the one to whom they owe unreserved allegiance.

At its best a church service calls forth in the participants a deep emotional response. It brings back tender memories of their loved ones and of those to whom they have most looked up, and it directs their attention back across the ages to a beautiful and luminous figure in whose life and teachings they see the norm by which to direct their lives. They see this figure glorified by a sacrificial death and exalted by the devotion of countless men and women who down through the centuries have responded to His appeal and have given all that they had to the cause He represents. These memories and associations can be used with telling effect by the able preacher, aided by religious symbolism and music, to stir the hearts and consciences of his hearers. Even those who are half-hearted in their devotion commonly turn to the church in the great crises of life when they find themselves standing on the threshold of the unknown. They turn to the church at the time of marriage, of the birth of children and of death, to seek its blessings and its support.

Not only does the church service call forth an emotional response, but it provides also an opportunity for instruction and for re-thinking the fundamental beliefs in the light of changing conditions and for modifying the ethical standards in the light of growing knowledge. Most sermons are anything but stimulating, but the pulpit is there for the prophet, when he comes; and the class meeting is a medium for the exchange of experience and belief on the part of the people. Church and synagogue have the enormous social significance and the fact that the Hebrew-Christian religion is the only one of the great ethical religions which has religious assemblage for instruction and common worship may help to explain why that religion has been associated with dynamic and changing cultures.

In the mental hospital the religious gathering will have a somewhat different significance from what it has in the normal parish. Where the normal church is based to a large extent upon the family unit and the congregation is made up in large part of those who are bound together by ties of love and friendship, the religious gathering in the hospital is made up of individuals. The social and familial ties are lacking.

These individuals are likely to have one important common characteristic. They are persons who have taken life seriously. They may be sharply contrasted with the inmates of a reform school or penitentiar

o very commonly have rebelled or failed to take seriously the loyalty resented by their parents and by the church. The non-organic type mental patient is one who has accepted that loyalty. Where the delinnt is judged by society, the mental patient has judged himself. There of course many mental patients who in the face of moral self-conination have thrown up the sponge and have withdrawn into a private ld of their own. There are many others who stubbornly refuse to it defeat or error and resort to all sorts of concealment devices in er to escape self-blame. But there are others, not a few of them, who themselves face to face with the ultimate realities of life, persons in m the better self is struggling desperately to gain control. For such sons the symbols of the church and of religion are likely to have prond meaning and it is among these that we find the largest proportion ecoveries.

It seems obvious that the ministry of religion in a mental hospital uld concern itself chiefly with the latter group, those for whom there till hope of rehabilitation. This does not mean that the leveled-off inutionalized patients and others of the less hopeful types are to be neged. On the contrary their true needs will best be met as we focus on se whose problems are still acute.

The task of re-education must then be taken seriously. The aim must not merely to re-awaken a faith which, in many cases, is based upon oneous pre-suppositions, but also to modify and re-direct it, to subute a wholesome religion for one which may have been associated with patient's difficulties.

In the service of worship, therefore, the problem is how to make use all available resources—music, pageantry, group participation, sern—to re-inforce therapeutically valuable suggestions. Religious emotion not to be looked upon as an end in itself, but as a means of re-making l stabilizing character. It is thus not to be regarded as sufficient that a ticular hymn or tune should win immediate acclaim. What is important he behavior sequences which result, especially in those who are in the cess of re-making.

In the working out of the order of service as given in this hymnal, the has been to provide for much participation on the part of the entire up, not only in song, but in prayer and response. There is also proion for change of position, standing for the Gloria, for the Confession Faith, for hymns of praise and action and commitment, kneeling or ting with bowed heads during prayer or during the singing of prayer mns. It is intended that these changes of position should succeed each er in such a manner as to be restful and stimulating. Care is thus en not to keep the congregation standing to the point of fatigue or sitg until they become restless or sleepy.

The order of service as thus worked out provides for both repetitio and variation. The following of a regular order, especially in a hospit congregation, is conducive to the orderliness and effectiveness of th service, and the repetition Sunday after Sunday of the Lord's Prayr, o the Confession of Faith and other selections of unquestioned value helps t impress them more deeply. Provision for variety may be made by th use of other prayers and passages of Scripture which deal constructivel with the problems of the patients.

In the selection of hymns and tunes it should be assumed that th words really matter. Tunes are important but their function is to re inforce the words and serve as an aid to recall. To those who may objec that we sing the tune and not the words, it may be pointed out that in pre literate times it was the general practice to put into verse and music thos things which it was important to remember. It seems safe to say tha to-day religious ideas are implanted more readily through the medium o hymns than in any other way.

Careful consideration of the words will of course rule out a number o well-known hymns, and other widely used worship materials. The follow ing are types of worship materials which should be excluded as likely t be disburbing:

1. References to enemies, as in the imprecatory psalms. Concer about enemies is a malignant reaction and needs no fostering.

2. Materials likely to re-inforce the belief in the authority of "voices and other subconscious promptings. For example: "O Christian dost tho see them?" evokes not only visual but also auditory and tactile hallucina tions and calls for action besides. The writer of this ancient hymn had u doubtedly passed victoriously through an acute psychotic episode, but h hymn is strong medicine for a congregation of mental patients. "O spea to me that I may speak," is a less striking example of a group of hymn which should be used sparingly in the mental hospital situation.

3. Materials likely to re-inforce belief in the magical. "There is fountain filled with blood" and "Rock of ages cleft for me" are represe tatives of a large group which give expression to a magical concept the atonement which is unsound therapeutically as well as theologicall

4. Materials likely to intensify the patient's sense of helplessnes fear and isolation. "Once to every man and nation" is thus a useful hym in summoning men to social action in times of national danger, but it do not help discouraged patients to be told that "The choice goes by forever "Before Jehovah's awful throne" and "O worship the King in the beau of Holiness" are other examples of a considerable number which repr sent God as a stern judge and ruler and are therefore of questionable valu

5. Materials out of keeping with the situation and mood of tho patients in whim we should be most interested. "Rejoice ye pure in heart

yful, joyful we adore Thee," "For the beauty of the earth," and "My
l I thank Thee who has made the earth so bright," are thus so out of
e that they must seem like mockery to the thoughtful patient. Many
ns while not disturbing, simply do not apply to the hospital situation.
e belong most missionary hymns, social action hymns and children's
ns.

The excluding of materials which are clearly unsuitable is of course
ely a first step. Then comes the task of selecting those materials which
t effectively bring to bear the great resources of the Christian faith
n the actual problems and needs of mental patients. The following are
categories which may be recognized in the materials which have been
uded:

1. Materials giving expression to the consciousness of sin and need
to aspiration for the better life. It is here assumed, on the basis of con-
led observation, that the consciousness of sin is a benign reaction[3],
t it may indeed be a first step toward the realization of higher possi-
ties and that the confession of sin, or guilt, brings release from the
se of isolation and estrangement, in which, rather than in conflict and
-condemnation, the most potent factor in mental illness is to be found.
Fifty-first Psalm, the General Confession and such hymns as "Father
is thy children humbly kneeling," "Lord Jesus, think on me," and "Im-
rtal Love, within whose righteous will" have therefore a place in this
ection.

2. Materials portraying the love and forgiveness of God. Those who
already undergoing severe inner conflict do not need to be reminded
God's sovereignty and majesty. They do need to be reminded that their
rld is under the control of friendly forces. Hence we say in our Con-
sion of Faith, "We believe that the sufferings of this present time are
to be compared with the glory which shall be revealed to us hereafter,"
use such hymns as "There's a wideness in God's mercy," "God is my
ong Salvation," "Here in this maddening maze of things."

3. Materials giving expression to attitudes of resignation and faith.
is assumed that from the religious standpoint spiritual maturity in-
ves the transfer of loyalty from the finite to the infinite and that de-
dence upon God becomes a source of strength as well as of comfort.
nce, such hymns as "Thy way, not mine, O Lord," "Father, whate'er of
thly bliss," "Still will we trust, though earth seem dark and dreary,"
e expression of these attitudes.

4. Expressions of courage and action. The need for these is obvious.
elieve not those who say," "Creation's Lord, we give thanks," "Father,
ar the prayer we offer," "He who would valiant be" are among the
mns of this type.

Exploration of the Inner World, (Willett & Clark, 1936)—chapt. 1.

5. Hymns of the Future Life. It must not be forgotten that there are not a few residents of the hospital community for whom the hope of a life beyond is about all that can make the present existence worth while. We see the expression of this hope in "Jerusalem the glorious," and "Hark, hark, my soul."

6. Materials dealing with special problems common among institutionalized patients:

Moods—"Twixt gleams of joy and clouds of doubt," "When we in darkness walk," "When shadows gather on our way."

Voices—"We pray no more, made lowly wise, For miracle and sign."

Locked Door—"Make me a captive Lord," "Not so in haste my heart."

Day-dreaming—"Abide not in the realm of dreams."

Frankness and Concealment—"Walk in the light."

7. Materials adapted to special purposes and occasions such as opening and closing of worship, morning, evening, Christmas, New Year's, Easter, Thanksgiving, Lord's Supper, etc.

The choice of hymns has to a large extent determined the choice of tunes. Given a fine hymn, the tune must be an appropriate one. Consideration must of course be given to established associations. The number of these associations is not, however, so great as might be supposed. Passing from one standard hymnal to another, one finds many variations. For a congregation made up of adherants of many different church bodies, as is the case in a large mental hospital, established associations are a factor in a relatively small number of cases.

In the 1932 revision of the hymnal we sought the help of two of the best advisers we could find, and we followed their advice, balking only in a few instances. The value of expert advice may be found in the fact that even though experts may differ one from the other, their differences will be far less than those of the rank and file and their judgments are far more likely to stand the test of our own best judgment later on.

One of the factors upon which our consultants laid great stress was that of pitch and range. In accordance with their advice about twenty of the plates in the original edition were discarded as being too wide of range or too high in pitch to meet the requirements of unison singing by the entire congregation.

In the book as it now stands there are 82 tunes. Of these 22 are in widest use, 38 are in general use and 22 are less familiar. A very few changes were made in established associations. *O Quanta Qualia* was thus substituted for *Morecambe* in the case of "Spirit of God, descend upon my heart!" *Martyrdom* was substituted for *Serenity* in the case of "Immortal Love, forever full." and *Hursley* was used instead of *Maryton* in the case

'O Master, let me walk with thee." The musical editor regarded these es as so far superior as to justify the change. In the case of the less iliar hymns and of those without established associations our aim was make use of the finest and most singable tunes available.

The printing of the entire hymn below the music was determined by purpose of permitting the hymn to be read for its meaning. When words are printed between the staves, this is difficult.

The purpose of a hymnal for use in mental hospitals and the needs ch it should seek to meet may thus be summarized:

The perpetuation and re-creation of religious faith through the re-animation of the historic Christian symbols, beliefs and personages.

Re-orientation with reference to one's accepted loyalties with confession of sin and need as an indispensable condition of right relationship with God.

Reaffirmation of the love and forgiveness of God.

Surrender and commitment in accordance with the principle that spiritual maturity is dependent upon the transfer of loyalty from the finite to the infinite and the building of the life upon that basis.

Orientation in time, making one superior to the trials and vicissitudes of the present existence.

Courage and action leading toward the realization of one's accepted goals.

Modification of morbid religious beliefs is to be sought by means of the usion of therapeutically valuable materials and by the exclusion of that ich is unwholesome and irrelevant.

It has now been eleven years since the latest revision. The book has come into wide use. It has been criticized chiefly on the ground that many of the hymns are unfamiliar.

The question which this paper is intended to raise is whether the nciples observed in its compilation can be accepted as sound, and ether it may not be possible to meet the objection regarding paucity amiliar hymns by the printing of a supplement made up of old favorites, mns which might not stand closest inspection but would be at least mless.

Suggestions regarding the hymns and tunes which should be included such a supplement will therefore be welcomed. We shall also welcome icism of the book as it now stands. Such criticism, to be helpful, should specific rather than general. We shall want to know what you disap-ve of and why. Above all we are eager for suggestions regarding the nciples upon which the book should be constructed in order to have ximum therapeutic value.

A CLINICALLY TRAINED RELIGIOUS MINISTRY IN THE MENTAL HOSPITAL

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Among the first questions usually asked when chaplaincy work for a mental hospital is mentioned are: "What has religion to do with the mentally ill? Isn't the patient already sufficiently preoccupied with religious ideas to be subjected to more religion?" From these questions attention is drawn to such evidences as the patient's frequent dwelling upon a morbid sense of guilt, or feelings of being forsaken or punished by God, or various self-renunciatory ideas which the patient states have been demanded by his religious beliefs and aspirations, or the rigid distinctions drawn by some between "good" and "evil" in human conduct. These questions, broadly speaking, bring into focus two major criticisms leveled at religion. In the first place, there are few serious investigators of the field of religion who will deny that much so-called religious teaching has been detrimental to the attainment of sound emotional health. This type of religious emphasis—and there is still too much of it—should, however, not be confused with the whole province of religion. As a matter of fact, one seriously questions whether this is religion at all; it would seem, rather, a gross perversion of it. To identify all religious teaching and practice with this emphasis would be as unsound as to dismiss all psychiatric practice as of no value because of the excesses of a particular school or branch of psychiatry. The second criticism which such questions suggest is that relatively little has been written about religion which has grown out of careful and critical clinical study. As such, it is difficult to present a subject like "religion for the mentally ill" without, at the same time, being subject to identification with the very religious emphasis which has worked such great harm in human living. This then would call, not for the dismissal of all religion and religious practice as "bad" because of the associations, but for an intelligent and prolonged clinical appraisal of its value in this particular area of human maladjustment.

For the sake of clarity and emphasis, a very short definition of religion is offered. Religion is conceived by the author to be that which deals with man's basic attitudes toward God, man and the universe, so that these attitudes can result in helpful relations with others. Attention is drawn to the fact that good religion has always maintained its concern with man's hopes and fears, his aspirations and his failures, his sufferings and tragedies, his purposes, goals and ideals, his hates and his loves, so that in his group life these can be life-building rather than life-destroying. Good religion has

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ght always to aid man in the attainment of such attitudes as would be ful in working out the necessary relations involved in the realities of his itual life. It is no accident that the Founder of Christianity emphasized maximims: "Ye shall know the truth and the truth shall make you free," "I came that they might have life, and have it more abundantly." In t, good religion is very much concerned with helpful living, or positive rpersonal relations.

It would seem then, if these observations are correct, that good religion a much needed place in the mental hospital. It is in the hospital that we such dramatic evidence of the failure of interpersonal relations. It her follows that this is so if it is accepted that fundamentally the illness n attempt on the part of the patient to seek a new orientation in the le of his system of values. Previous patterns of living having failed , the psychosis might well be considered a rather desperate attempt on part to attain a new adjustment. This would seem to identify the illness f as a "value struggle," and whatever resources can be brought to the ent's aid in the struggle will be of help so that the results can be positive er than negative. It is at this point that stress must be laid upon those udes which will enable the patient to reconsider some of the factors h were insrumental in bringing about the illness. This is where good gion can make its most distinctive contribution through the wise appli- n of its resources as a faith and practice.

It is well to emphasize that the traditional methods of religious instruc- have little place in a mental hospital. It is becoming increasingly clear , before any religious worker can be of help to those who are emo- ally ill, he must have some adequate understanding of the illness situa- . Thus it is coming to be demanded that the theological student or gyman who intends to specialize in this field must first have undergone ll year of clinical internship, under the supervision of a trained chap- , in such institutions as general and mental hospitals, and a prison or formatory. This usually succeeds in providing a beginning for under- ding some of the dynamics of human behavior and enables the religious ker to make an intelligent and helpful application of the resources in- nt in religious tradition. Without this training and understanding, it lt that any religious worker stands in serious danger of doing more n than good in such specialized work as the care of those who are tally ill.

Ministry to the Newly Admitted Patient

When the author first began his ministry as a chaplain in a mental hos- l, Dr. Arthur P. Noyes, the superintendent, offered a very helpful sug- ion. He felt that the chaplain could do much to prepare the way for apeutic work on the part of the hospital staff by interviewing the pa-

tient as soon as possible after his arrival. It was his suggestion that the chaplain interpret the hospital to the patient: tell him something of its procedures and of its concern for his welfare, something of what he might reasonably expect by way of treatment, and, in general, to help allay some of the anxieties attendant upon his hospitalization.

This approach has always been found both meaningful and helpful and it has come to be accepted as standard procedure in all trained chaplaincy work. In so far as is possible all new admissions are seen routinely by the chaplain's department. However, there have been some significant additions in points of emphasis which have tended to make clear the chaplain's distinctive role in supportive therapy.

It has long been recognized that religion is a source of strength to people when they meet the inevitable stress situations of life. Of course, it is right here that much criticism has been levealed at religion. This has rightly been merited whenever the religious emphasis or practice has sought to evade the realities of a given situation. Loss of position, changes in social status, sickness and death are among the most difficult experiences which people have to face. At these times they need all the strengths and resources available to them, and it is here that religion has often had its most significant ministry.

The newly admitted patient to a mental hospital is faced with his own unique constellation of anxiety-producing factors. He is often thrust into a situation which has not been of his own choosing. Frequently, he regards this as a betrayal or a kidnapping, depending upon whatever unwise method was used to obtain his commitment. It is a situation which carries with it a great deal of social stigma, which, to say the least, is in no way helped by the usual legal forms of commitment procedure. Then comes the great concern about his future, to say nothing of his fear of being in the hospital for life: What will people say of him since he has been in a "place like this?" And above all what chance will he have of obtaining a vocational placement should it ever become known that he has spent some time in a mental hospital.

This, then, is a situation which is marked by its increase of anxieties. There is of course the inevitable anxiety inherent within the illness itself and this (coupled with all the other fears) makes this patient peculiarly susceptible to any good supportive therapy. Religion, in the best sense of the word, has this support to offer through the wise use of such resources as counseling, prayer, worship, doctrine, the scriptures and the sacraments to mention only a few. If these resources are used, they can prove helpful in reducing the patient's tension, and then can aid in the acceptance of the situation as it is.

For the purposes of illustration an actual case will be quoted. The patient was a 37 year old chaplain with the rank of lieutenant-commander

he Navy, having served a little over six years. He had come to the ital with some marked feelings of unworthiness and depression which e incurred while aboard an aircraft carrier in action. He had seen ain twenty-four hours following his admission and on referral of the itting physician. He appeared rather fearful and was in our "special ip" reserved for potentially suicidal patients. The interview opened a his question as to when he was to have a court-martial for his failure uty. He talked fairly freely about his feelings and the development is illness, but showed great preoccupation with his sense of failure having let his men down when he was most needed. Among other gs, he mentioned his concern about being in a hospital like St. Eliza- s. There appeared some obvious conflict of feeling, since he thought ad no right to be here and ought to be shot, and yet, on the other hand, that he was "in a place like this," he quite likely would never get out. n, even if he did, what about his future in the ministry? He felt the le thing was hopeless. He said he couldn't write to his wife, who was t home and knew nothing of his return to the States, but did ask the lain to write for him.

How was this interview conducted? It lasted for about forty-five min- . In the first place, the patient was allowed to talk with relatively few rruptions. When questions were asked, they were largely in response rtain leads he had already given, which indicated something of what he ted to say but which he found difficult to put into words. It seemed that ery much needed somebody to accept with him some of the things which, gh all too real, were still unacceptable to him. For example, he hadn't ted to come to the hospital, but he was in it nevertheless; it was also a that he had not been able to do all he wanted to do in his job as a Navy lain; he was in a mental hospital, a situation which carried a great deal cial stigma; he was going to be in the hospital for a not inconsiderable od of time, and there was nothing he could do about it; and, finally, nts who came to the hospital were not court-martialled, even though urged ever so strongly that they had failed in the line of duty. It was ssed with him that he had a real illness, that it was this illness which e it impossible for him to do what he wanted to do, and that that which happened to him had happened to many other people. Attention was wn to the experience of Dr. Anton T. Boisen, himself a clergyman who undergone a severe psychotic upset. He had come out of the mental ital with insights he had not had before, and which resulted in his ding The Council for Clinical Training, which made it possible for gymen to study and work in mental hospitals. It was agreed that things ook black at the moment—this was the early part of the illness—but they would not look so bad after he had experienced the skilled help of nospital staff. Something about mental illness was discussed with him sponse to questions, especially society's attitude toward it. This latter

was contrasted with the facts as they really were and the way those in th hospital regarded it. He was encouraged to cooperate to the fullest wit all on the hospital staff, and told something of the understanding that h would obtain in the hospital which was not possible elsewhere. Finally he was assured that the hospital would use every possible means to offe him the best that medical science had to afford.

At this point, the question might well be raised: "What here was i any sense different from that which might have been done by a doctor or social worker?" The answer to that could only be: the person who did and the particular methods employed. The essential body of informatio is almost invariably the same. In this case, the interviewer was neithe a doctor nor social worker but a clergyman, and this has its own uniqu psychologic significance. Something of this will be touched upon in a late part of this paper. Also the illustrations used in talking to the patient, th language spoken, the methods employed, were different from those of an other professional worker. The hymns of the church were used as quota tions, the Bible and especially the Psalms (which to people acquainte with religious literature are well known hymns of hope in the midst o great anguish of spirit), the great doctrines of the church—especially fo giveness, the development of the counselling relationship so that it wa able to bring forth the real values of the confessional and, finally, good us was made of prayer. This, however, needs to be emphasized—these re sources and practices of the church were used not just for the sake o using them, or because it was expected that they be used, but as definite an meaningful helps in a given situation of human distress in which their us was indicated. Before the interview was concluded there was a brief praye (something which incidentally is seldom used with a patient until succe sive interviews), which was suggested because there were obvious sig that it would prove helpful. In this prayer it was attempted on the pa of the chaplain to use both strengthening collects and extempore prayer which the discussion of the interview was offered to God. It seemed tha when both the patient and the chaplain joined in the Lord's Prayer, ar just before the patient received the Blessing there was some change him not noticed earlier in the interview. This is the sort of thing which meant when it is said that religion, intelligently applied, has many r sources available to help lessen the anxieties present in so much of th illness. And it is submitted that if these anxieties can be lessened and th patient helped to accept the illness, he had that much better chance recovery.

The Ministry of Worship

One of the most impressive phenomena about mental illness is th feeling of personal isolation evidenced by the patient. At times this seem to be expressed in terms of the social stigma usually associated with th

-ss, though it is more often symbolically revealed in the many elaborate ifestations indicating the presence of marked feelings of guilt. These ts, one suspects, are provoked by the thrust into awareness of previ- unacceptable personality tendencies or desires. Whatever the cause ne feeling of isolation, the fact remains that the patient either believes cts, or both, as though he were not an acceptable member of the com- ity family. Since so much of this feeling is expressed in terms of sonal unworthiness" or "guilt feelings" or "feelings of being sinful," it ediately becomes a problem for religious concern. This is of course anguage of religion, and it is no accident that often patients who have little formal religious instruction or interest will express their guilts tating, "God has forsaken me." This is the chaplain's opportunity for her supportive therapy in his use of the worship ministry.

It has been the author's experience that the regular worship services, n meaningfully applied, can be of great value in counteracting the ng of isolation. In these services, which we are reminded are a group ity, the patient is encouraged to join with others in many strengthen- relationships. He unites with them in the repetition of prayers, re- sive readings, hymns and affirmations of faith, all of which have been fully selected so that they provide support of the patient while he is ne process of working through his basic drives and difficulties. Also in group expression of common feelings he comes to recognize and to ac- , by the very things he says and hears with others, that he is not dif- nt or alone in his particular experiences. As an example of what is nt by a religious group activity which is supportive in its emphasis, e is quoted the *Hospital Affirmation of Faith.* This has been written cially for the patients in this hospital and is used at every service.

Hospital Affirmation of Faith

We believe in God who is like a good father:
He is near to us, and strong to help us.

We believe in Jesus Christ, in whom we see God:
He is for us the way of truth and life.

We believe in the Holy Spirit whose life is in us,
Giving us new life and healing strength for our spirits.

We believe our faith is a confident trust,
In the truth and goodness of God.

We believe our hope is a power, to fill the present
And the future, with deepest meaning.

We believe our love is the means by which
This faith will be made real in our lives.

In such group activity it has been discovered that, through the use carefully prepared and intelligently applied sermons, much can be done lay the groundwork for the future consideration with the patient of certa troublesome feelings brought into awareness by the illness. By this doi of things together, through a socially significant and approved medium, t religious service, the patient frequently finds yet another effective means socializing. Often it is in just such services that a bridge is found by whi the individual is able to get back to the community in which he had fou it so difficult to adjust before his illness.

The Ministry of Councilling

The opportunity to talk things over with someone not involved in t situation can frequently be most helpful to those who experience emotio distress. When the person talked to is friendly, understanding and p missive in his attitude, we have the necessary factors which prepare t way for good therapeutic results. This would appear to be of the essence f psychotherapy. It is here that the chaplain has another opportunity to be help to the mentally ill, for traditionally people have long looked to t minister as one to whom they could go for help with their problems in li ing. It is felt that this opportunity is doubly significant in the clergyma function, since there are operative in his relations with others certain ps chological factors which do not pertain to other workers in the allied p fessional fields. For this reason, the chaplain occasionally accepts referra or will follow up initial interviews with patients, on a much more intensi level.

It has been a matter of growing interest to the author to discover h patients relate to the chaplain. To many he is obviously a representati of an organiaztion, the church, which is not confined to the hospital alo As such he is never distinctively "hospital," as are some of his fell workers. This very fact, pointing as it does to his connection with t community, can have great significance for the patient. Some of its i portance is recognized when the patient interprets the chaplain's visit the community's active concern for his welfare at the very time when, reason of his own inner conflicts, he feels most estranged from it. Imp tant as this aspect of his relationship is to the patient, it is still only o part of it.

Whether it is liked or not, the fact remains that most people react a clergyman as though he were the symbol of their conscience. This mig well be illustrated by experiences common to all parish clergy who hear frequently as the first remark made by the person visited: "Oh, you kno I intended to come to church last Sunday, but..." Why this is so see fairly apparent. The minister has come to be associated in the minds people as the representative of the judgmental, prohibitive and condem

aspects of society. Indeed, the church and religion seem most frequently to be reacted to in just this manner. Let us now examine what significance this has for our mentally ill patient.

The patient is frequently, as had been indicated, one who already feels too keenly his severance from the community. And what is of importance is that he feels himself responsible for this relationship precisely because he harbors desires and impulses which are at variance with what he knows or understands of society's demands. In this he often interprets the chaplain's visit as a possible condemnation or attempt to pass judgment upon him. But he quickly discovers that the reverse holds true. Instead of being criticized, he finds no condemnation, but rather a friendly understanding interviewer. Where he expected to be lectured, he finds a permissive listener who says little and appears to know something of the difficult experiences he has been through. This reversal of what has been expected has shown itself many times to be extremely helpful in aiding in verbalization, frequently for the first time of many things the patient has hardly been able to admit to himself. When a good relationship has been established, the chaplain can be of help to the patient in a process of reorientation for the attainment of more socially valuable and acceptable methods of dealing with difficult life problems. It is in this counseling relationship that the chaplain can draw heavily upon the educational contributions of both religion and the church.

Educational Aspects of the Chaplain's Ministry

COMMUNITY RELATIONSHIPS:—What has been considered so far in general covers the major aspect of the chaplain's work. His ministry must always begin with the spiritual needs of those with whom he works, all else is a derivative of this emphasis. However this is not all the chaplain is called upon to do. By virtue of the fact that he represents a community organization—in St. Elizabeths Hospital this is the Washington Federation of Churches, itself made up of twenty-three different church communions—he has a responsibility to discharge to the community. This of course provides for a great educational opportunity.

In the course of a year the chaplain is called upon to give a great many lectures in the community related to the nature of his work. In this way he is able to interpret the hospital and its function to the community. In experience it has been found that the lectures, sermons, talks or addresses he has been called upon to give touch upon a vast array of subjects, many of them indicating the interest and concern of the community. For example, people have wanted to know something about the nature and treatment of mental illness, what is known about the causes of mental illness, the community attitudes toward the illness and the patient, and something of how the community treats the discharged patient. They have

further asked for suggestions as to educating for the prevention of mental illness, and providing for good mental health; also the function of religion in the prevention of illness, religion and personality adjustment, religion and mental health. Considerable interest has been shown in how the church might aid in helping the discharged patient readjust in the community and how the church might do something toward helping remove the stigma usually associated with mental illness.

Attention should be drawn to the fact that these lectures and addresses have been called for not only by church groups but by many other community organizations interested in this particular problem. They provide an extremely significant medium by which the insights gained in the hospital can be conveyed to the community, where they might be of help in attacking the problem of mental illness at its source.

THEOLOGICAL EDUCATION:—Perhaps the most marked feature of the chaplain's contribution to the community is a course of study conducted in the hospital which has come to be known as "Clinical Pastoral Training." This is a relatively new venture, both in psychiatric as well as theological education. It was begun in 1925 with Dr. Anton T. Boisen, then chaplain at Worcester State Hospital, Worcester, Mass., and has been ably pioneered by such figures as Dr. Richard Cabot, Dr. Helen Flanders Dunbar (who was the first director of The Council for Clinical Training, Inc.), Dr. Lewis B. Hill, Dr. Thomas French and others. As a result of this emphasis, it has become increasingly clear that, in order to be able to minister to people, the seminarian or clergyman must first obtain some experience in working with people. It is this experience which clinical pastoral training seeks to provide in offering opportunities for intensive clinical study of problems in the realm of interpersonal relations. The program has been well defined as: "A supervised experience which seeks to make real to the student in understanding and practice, the methods, resources and meaning of the Christian religion as it is expressed through pastoral care."[1]

The cardinal emphasis of the training program is to orient all the student's studies about his contact with patients. As a result of this, and by means of careful observation, note-writing and seminar discussions, it is intended that the student gain a better understanding of people and their needs. In the course of seminars and lectures and in intensive life-history studies, the students are helped to obtain insight into the processes which make for personality development, what happens when this development is thwarted, and the means by which ideals can and do help in the formation of personality patterns. As the student comes to a deeper understanding of

1. Morris, Robert D., Chaplain, The Episcopal Hospital, Philadelphia, Pa.: The Essential Meaning of Clinical Pastoral Training, in Clinical Pastoral Training, Seward Hiltner, ed. The Commission on Religion and Health, Federal Council of Churches of Christ in America, 1945.

uman problems and infirmities, he is taught adequate methods of working vith those who show these difficulties, and thus comes to see more clearly is place among such specialists as the psychiatrist, internist, social worker, urse, psychologist, occupational therapist, director of psychodrama and thers, who are all helping remove the obstacles to successful living. The eminarian or clergyman comes to the hospital as a student, that he might etter understand his pastoral function and make more adequate use of is own distinctive resources and technics. In this role he profits from the nsights and experience of other professional workers, whom he comes o know better, and in this way comes to find greater meaning and opportunity in the Christian ministry which is his area of service to others.

ummary

It has been attempted in this paper to present a brief account of the alue of a clinically trained religious ministry for the mental hospital. It vas pointed out that the answer to the experience of the past is not the voidance of all religion but the demand for an intelligent evaluation and pplication of what religion has to offer the patient in his struggle to get vell. It was suggested that religion has a distinctive contribution to make o those who are mentally ill, but that its resources and practices must be nderstood and intelligently applied to the illness situation. This requires clinically trained minister.

The trained ministry can contribute to the patient's recovery by:

(1) The ministry to the newly admitted patient, who is seen as soon as possible after arrival. The very anxieties inherent in the illness itself and which are usually aggravated by the fact of hospitalization can be lessened by the supportive therapy which religion has to offer. Religion is recognized as a support in crisis situations.

(2) The ministry of worship was suggested as another resource and can be a valuable adjunct in developing group feeling and helping to overcome the feeling of isolation so prevalent in mental illness.

(3) The ministry of counseling was indicated as another opportunity for the trained chaplain, this time to work with referrals or follow-up interviews. It was seen that the minister, by virtue of the unique psychologic factors involved in his role and the resources at his disposal, has excellent opportunities for therapeutic results.

(4) The educational aspects of the chaplain's ministry. Here were pointed out the community relationships and opportunities for the interpretation of insights gained while working in the hospital; also, the work of training clergymen and seminarians in a course of Clinical Pastoral Training.

INTERNATIONAL CONGRESS FOR MENTAL HEALTH, *London*, August 11-21

The Congress is sponsored by the International Committee for Mental Hygiene and has three important objectives: (1) to effect the most complete exchange of knowledge, experience and techniques in the field of mental health possible and to effect this exchange as quickly as possible, (2) to disseminate information regarding the Congress findings as broadly as possible to all those concerned with mental health, and (3) to bring into being the nucleus of a permanent worldwide voluntary mental health organization to carry out an active program for the promotion of mental health. The conference will be held under distinguished profession and lay leadership. Dr. J. R. Rees, Chief Psychiatric Consultant of the British Army, is the chairman.

The Congress will consist of three International Conferences. The first on the citizen of tomorrow—today's children. Areas to be considered are: aggression in relation to family life, psychiatric problems in the educational sphere, the community and the aggressive child. Efforts will be made toward understanding what the war has done to the children of the world and what can be done about it.

The second conference will have to do with psychotherapy, and the main concern will be the genesis and dynamics of guilt and the advances in group and individual therapy.

The major part of the program will consist of six days of discussion on the theme "Mental Health and World Citizenship" and the topics to be consdiered include: problems of world citizenship and group relations, the individual and society, family problems and psychological disturbance, planning for mental health (organization, training, propaganda), mental health in industry and industrial relations.

It is believed by the organizers of the conference that prompt action is necessary if the contribution of the workers in the field of mental health is to be accomplished. In the ten years since the last conference in this field, much valuable insight has been gained into the mind of modern man, but this understanding has been developed in almost complete isolation and it is clear that today there is a need for worldwide mobilization of professional knowledge. The Congress will present the thinking of all the groups concerned with mental health in psychiatry, psychology, sociology, anthropology, in medicine, education, nursing, and of the clergy and other persons with special competence or experience in the field of mental health.

It is expected that at least 2,000 persons will attend. They will come from North and South America, Asia, Western and Eastern European countries. A great deal of the work is being done beforehand through

preparatory groups. One of them, the Bellevue Commission, has presented material on Mental Health and American Protestantism, and is reporting the work done by Council supervisors. Some 83 groups are at work on reports in this country, and other groups are at work in other countries.

It is planned that the proceedings of the Congress will be published. It is expected that the continuing organization of the Congress will become the official voluntary consultive Agency in the field of mental health for the World Health Organization of the United Nations.

$100,000 has been contributed toward the cost of the conference from this country and $150,000 is still needed. Contributions will be gratefully received and may be sent to the Executive Officer of the International Committee for Mental Hygiene, Dr. Nina Ridenour, 1790 Broadway, New York 19, New York.

It is expected that this pooling of proven experience from many different fields will accelerate the application of mental health principles, and that in the continuing organization there will be the instrument of cooperation between social scientists all over the world.

MAN FOR HIMSELF, by Erich Fromm.....254 pp.
(New York, Rinehart, 1947, $3.00)

This book, by the author of *Escape from Freedom,* makes a much needed contribution toward building a bridge between psychoanalytic theory and philosophical ethics. For more than a generation now, a widespread, constructive rethinking of ethical problems should have been going on as a result of the discoveries of psychoanalysis. Instead, much psychological literature, in an attempt to be rigorously scientific, has either ignored problems of value entirely or has taken a reductivistic attitude toward them. And although both Freud and Jung attempted to delineate a *Weltanschauung,* the former was naive and dogmatic as a philosopher and the latter is often downright spooky (though he also makes fertile suggestions) when he writes as a religious visionary. Ethical theorists, on the other hand, have tended to pigeon-hole psychoanalysis in accordance with traditional concepts and disputes; those who do not like it have dismissed it with well-worn refutations of psychologism, while those who welcome it have regarded it as confirming the relativism and hard-shell determinism which they knew to be right anyway. In neither case have the moralists examined their problems afresh, in the light of the authentic expansion of our knowledge of human nature which psychoanalysis makes possible.

Thus what Erich Fromm's book inaugurates may turn out to be more important than the conclusions it reaches. Against psychological hedonis, relativism and reductivistic naturalism he maintains that psychoanalysis can provide a basis for objectively valid norms in ethics. But against all those who see, potentially, a close alliance between psychotherapy and the churches, he maintains that this ethic must be humanistic—in an "anti-God" sense of the word.

On the assumption that most of those who see this review will either have read the book for themselves, or will do so soon, I shall confine my remarks to a few general reactions instead of trying to summarize its contents. Fromm's agrument is so carefully wrought that adequate exposition or criticism would require lengthy treatment. First I shall list some of the points which are especially illuminating and are established with great skill and penetration: (1) Man is not simply a passive puppet in relation to cultural patterns, but has an internal psychological structure in terms of which he adapts or resists; (2) many of the concepts of traditional ethical theory remain highly ambiguous and abstract unless they are understood in connection with the character-structure of the individual; (3) irrational authority has estranged man from his own feelings, tended to split him asunder, and stifled his creative capacities; (4) the "marketing

ientation," as a prevalent contemporary neurosis, has reduced its victims a set of automatic functions, enslaving them to anxiety and externalism ider the guise of serving self-interest; (5) selfishness and self-love, instead of being synonymous, are actually opposed; capacity for loving hers is conjunctive with a capacity for loving oneself; (6) although there e some dichotomies in human nature which cannot be removed because ey are inextricably connected with man's distinctive capacities, many of e cultural and personal conflicts which hitherto have been regarded as remediable are due to man-made conditions and are therefore alterable. his list does not include any reference to Dr. Fromm's attempt to reinterret conscience, faith, and the concept of "universal" validity on the basis his humanistic approach; but it may serve to indicate the comprehenveness and fruitfulness with which he has conceived his task.

So far as criticism goes, I shall confine my remarks to a discussion of vo omissions, without attempting to decide whether they are due to the ct that an author cannot say everything in one brief volume or due to e fact that Dr. Fromm feels no need for further substantiation of his gument at these points.

(a) Because so much theology does incorporate elements of what he lls irrational authority, he writes as though in the Jewish-Christian tration God were primarily conceived as an arbitrary, puritanical despot. e ignores those interpretations which find belief in God necessary, not order to impose standards upon men which are incompatible with human atitude, but precisely in order to account adequately for the fact that an seeks to develop his own moral capacities and to criticize his own acons and attitudes on the basis of objectively valid norms. Apparently r. Fromm feels that since it can undoubtedly be shown that reason (when oadly enough defined is *man's* instrument of critical self-direction, and ve *can* be incorporated in life as a *human* quality, and conscience *can* be means of increasing *man's* capacity for responsibility instead of his ression and self-enslavement, therefore it follows that these human aracteristics have no relationship to anything superior to man. This is flagrant *non sequitur*. Yet he writes as though the instant that discuson of what is good or bad for man were set in a theological context, all e gains which he expounds through psychoanalytic insight into ethical oblems would instantly be lost. So far is this from being true, that the nly portions of his contribution which would not be taken over bodily to a Christian interpretation of man are those passages where Dr. Fromm serts, without supporting evidence, that man is alone in a universe indifrent to his fate (p. 44) and then allows the consequences of this assertion dictate the perspective from which he views ethical concepts.

(b) The other omission is closely related to the first. Repeatedly roughout the volume Dr. Fromm refers to man's "potentialities," and

in his discussion of the "productive orientation" he leaves the reader in no doubt as to what he means by a good, full, satisfying, harmonious development of these potentialities (as contrasted with their opposites). Yet when one asks why human history is so prevailingly a story of how man has gone against these inherently good possibilities, the answer is extraordinarily weak. While there can be little quarrel with what Dr. Fromm wants to affirm and to see enhanced in human nature, the plain truth is that these qualities represent a highly selective segment of the total evidence concerning what man is. One can share his hope that these potentialities will become increasingly predominant over all the negative and destructive factors in human history, past and present, which have to be explained away in order to "affirm human nature." But these areas of agreement need not compel any reader to emulate the author in failing to discuss th sense in which man, besides being capable of responsibility, is also dependent upon forces beyond his own will and wisdom, both for creativity and for the holding in check of anarchy, injustice, cruelty and megalomania. Dr. Fromm is compelled to locate both the creative and the stabilizing factors exclusively in man because obviously nature (when considered apart from man(provides no ethical resources for either. He is compelled to represent the shift from non-productive to productive orientations as something which man does "all by himself," so to speak, despite the fact that virtually anyone (including psychoanalytic patients) who makes the shift feels in the process that it is at least as true to say that something creative and emancipating is happening *through* him as that something is being done *by* him. In short, the attempt to locate the healing powers of the universe exclusively in man, simply because they undeniably operate within man, seems not only arbitrary but short-sighted, because it severs the link between ethical problems and theological problems.

Thus the criteria whereby Dr. Fromm would direct man's capacities toward productiveness are left hanging in a cosmic vacuum. They presuppose a radical religious and ethical transformation of the race, and they will commend themselves only to those who have been so transformed or who long for such a transformation. So far from being an affirmation of "man," they are actually an affirmation of what is capable of creativity and redemption in man. They cannot be set forth as commending themselves to "reason" without presupposing a converted character-structure (of which a properly functioning reason then becomes the natural and enlightened guide). Insofar as these criteria have been fulfilled in the past and insofar as they may be fulfilled in the future, inherent endowments and developing capacities in man certainly provide the source with which we are directly in touch; but Dr. Fromm says nothing (apart from the negative *caveat* already mentioned) concerning the cosmic value-structures from which these endowments derive and in interaction with which men develop or destroy the capacities he prizes.

Because he virtually ignores the Christian diagnosis of human ills and ıe Christian conception of their remedy, he also does less than justice :o put it mildly) to the humanitarian contributions which have issued om this religion tradition. (The "authorities" of the humanistic tra- tion to which he appeals—though not uncritically—are Aristotle's ethics, ɔinoza and Dewey.) Indeed, he is much more interested in exploiting a ıe-sided criticism of the Reformers (albeit what he selects for censure chly deserves it) than in understanding what an enormously valuable liance for the promotion of his own ethical aims might be formed with ıristians who—if they are to be honest—must differ from him in linking lf-realization to faith in God, inward freedom to service of God, and lf-acceptance to divine forgiveness.

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IND AND BODY: PSYCHOSOMATIC MEDICINE, by Flanders Dunbar, M. D. ix and 263 pp. (New York, Random House, 1947. $3.50)

Today many doctors, especially those with psychiatric training, are king a real interest in the total person who is ill, as well as in specific mptoms, organ systems, or disease entities. Amazing insights into the ıotional nature of much sickness have rewarded the research doctors ıo have approached their patients as human personalities. Dr. Dunbar, ıo was prominent in the establishment of the Council for Clinical Train- g, is one of the pioneers in this new approach called psychosomatic medi- ıe. Here she presents in lay language an interpretative summary of r findings.

The pastor who desires to understand both himself and his parish- ners will be astounded at the closeness of the relationships which often ist between specific personality patterns and types of illness. Hyperten- ɔn, migrain, asthma, peptic ulcer, fracture, allergies and diabetes are ıong the medical problems which Dr. Dunbar presents in terms of the rsonality structures of the patients. The part which unsolved and often ıconscious emotional problems play in the person's illness are clearly esented by Dr. Dunbar.

The abundance of clinical material which illustrates each chapter kes a readable and stimulating book for the medical "layman," whether be pastor, chaplain or prishoner. The discussion on "The Mind and e Heart" contains, for example, the case record of a patient suffering ɔm severe pain originally diagnosed as an acute form of rheumatic heart sease. She described her illness in more personal language: "The Lord

strikes knives into the hearts of his children who err. I guess that's what happened to me." After being hospitalized three separate times for attacks severe enough to require an oxygen tent each time, this patient requested psychiatric help. Two months later, after five sessions with the doctor, she was allowed one day to get up for dinner where it happened that the guests were people involved in her emotional conflicts. The next morning she woke up gasping for breath. Her husband and the attending physician prepared to rush her to the hospital, but she insisted on seeing the psychiatrist first. "Well, you were almost too late," she gasped in a hoarse whisper . . ."I'm going to die, but I wanted so much to wait till you came. I wanted to confess. I'm no good. I guess I'm done for. I can't help being attracted to A—. I hate my husband. I'm being punished." In a thirty-minute visit in which the psychiatrist pointed out her extreme anger, her pulse went down from 150 to 90 and she was able to relax and sleep comfortably, to the obvious surprise of the attending physician, the nurse and her husband.

This sickness occurred twelve years ago, and after further help the woman has had no more attacks nor have her activities been limited in any way. She explained, "Until you made me face what was really bothering me, and showed me I could do something about it, life was impossible except when I was sick. It may sound funny to you, but it used to be a relief to have a real pain to fight, instead of my husband and all the people I hated and felt despised me. What I used to call 'the knife in my heart' hurt so much that it blotted out everything else, everything that bothered me."

If the pastor deals with the real-life situation of his parishoners, he will be both encouraged and frustrated to see the close relationships which exist between feelings and bodily health. These relationships have implications for pastoral and systematic theology, which while disburbing at first sight, are deeply revealing on further study.

Perhaps the minister who prescribes spiritual advice for his congregation in the pulpit, study, home and sick-room, will be dismayed to learn of the number of patients in certain types of sickness who have received an abundance of such advice, and who yet remain ill. Or to learn how they suffer the lack of any genuine love from parents who yet join in regular religious activities. The hospital chaplain certainly observes many people to whom some forms of Christian salvation have not brought the health and joy one associates with Christian faith. The pastor, however, who understands and accepts his flock as individuals with varying capacities for Christian growth and with differing God-given resources for health, will be able to gain insight into the complex dynamics by which disturbed feelings contribute to the development of some illness.

The pastor or chaplain should not be misled by the deceptive simicity with which the treatment of specific patients is described in this ook. It is neither a textbook in psychosomatic medicine, nor is it a book be distributed as a "self-help" to parishoners who are ill. Some of Dr. inbar's statements about specific relationships will no doubt appear too sitive to many other students of psychosomatic medicine. Many carel research workers have been more cautious. Nevertheless, reading this ok will stimulate the pastor to a recognition of the values of self-underanding, knowledge and caution in his ministry to his parishioners, both e sick and the well; and help make clearer new possibilities in the minry to the parishioner during illness.

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SYCHOANALYTIC THERAPY, by Franz Alexander and Thomas Morton French ..... 353 pp.
(New York, Ronald Press, 1946. $5.00)

This is a most important book in a number of ways. It is the product seven years research at the Chicago Institute of Psychoanalysis into e puzzling problem of the relation between therapeutic results and the odes of treatment. All the cases given, twenty-one of them, are examples short-term therapy; but we are told that cases of longer duration could ve been used, which would have involved (as many of these cases do not) three "standard" techniques of psychoanalysis, namely the couch, freeociation and dream interpretation. Many of the cases here involve oblems thought too slight, too severe, or ones with too many organic mplications for psychoanalysis. One does not get the sense, however, that is work is rebellion against older standards: the writers do not think the uch a Procrustean bed; rather they have observed that analysts used select patients who already could fit the bed. Their work then has been ward a more flexible use of technique to make possible, not only shorter d more effective therapy, but also its wider usefulness.

They face the question whether this can rightly be called psychoalysis. Making a practical use of the older theoretical distinctions beeen psychoanalysis as a body of knowledge and as a method of research o emotional disorders and as a method for their treatment. The authors cide that any therapy "*based on psychodynamic principles* which attempts bring the patient into *a more satisfactory adjustment to his environment* d to assist *the harmonious development of his capacities* . . . may be conlered phychoanalytic." (italics theirs). Hence the title. After all, anats have always, it seems, felt professionally justified as analysts in sendg a bill for professional services rendered when their service was a deci-

sion that the patient could not profitably use analysis! The book is throughout characterized by the views of an informed common-sense. What is proposed is, however, no easy short-cut in psychotherapy for the physician; instead there is constant demonstration that the more flexible use of technique requires an even more uninhibited intuition, highly trained and very skilled.

No doubt this experimental work will receive a mixed reception in psychoanalytic circles. Yet, whatever final judgment it merits, the work is outstanding as the first full-length discussion of technique that examines, not how certain procedures are to be used, but why they are used. There is no immodesty in the author's view that this type of experiment, going on in many places but now systematically explained, is a step forward in psychoanalytic work, comparable to Freud's discovery of free-association or his elaboration of the transference neurosis.

The presentation of these views is remarkable in another way, for the book is a most successful symposium with apparently all of those advantages and none of that unevenness and lack of coordination which we have learned to expect of a joint authorship. This is the more amazing in that the book represents the work not only of the two authors but also of nine of their colleagues; yet it is all of a piece (and, we must add, a piece of remarkably clear and readable writing). The differences of one person from another are not lost, however; and the various interests and specializations, the several kinds of personality and the variety of types of successes they have and even the miscalculations to which they have found themselves liable are all in the picture.

What is most striking about the book is its acceptance of the analytic process in terms, not only of its symbolic meanings, but also of its place in the realistic life situation. It says many things that the public has always known but it frees them from popular misconceptions. For example, it is obvious that in some way psychiatric work involves the influence of one human being upon another; here the question is faced how much and what kind of influence is diagnostically indicated. Or again, at least the friends of every patient know that a great deal of the healing process takes place out of the therapist's office, even as did the disease process. Here there is clear recognition of this reality factor. This understanding of how life is lived, externally as well as internally, makes the book a useful introduction to an inquirer. It omits exposition of theories used; it does not stop to explain many basic concepts mentioned; but it gives a very clear idea of what genuine realistic, therapy is trying to do.

For the minister who has some working understanding of the psychodynamics of his own counseling and pastoral duties, this book makes explicit much about his own services to people, his own practice in deciding

iom he can help and whom he should refer elsewhere, how he can help st, by environmental change, by continued moral support, or by extended erviews, how much dependence upon himself to allow or to alleviate. nat is not explicit or even implicit in the discussion is any indication how s psychotherapy is to be distinguished from help given by other pro- sional persons when given on the basis of a psychodynamic understand- , by the consulting psychologist, by the social caseworker, or by the stor. That is a problem perhaps rightly left for discussion between pro- sions on the basis of such findings as these within a profession. This ume helps toward that, but already by itself it is a source book, a stand- l of comparison, and a manual of suggestions for all modern pastoral nseling.—T.J.B.